Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DANA MAGRUDER
PO BOX 153105
LUFKIN TX 75915-3105

Respondent Name
New Hampshire Insurance Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-3139-01

MFDR Date Received
July 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Each of these charges are separate and apart from each other and are not bill by any other service or paid to any other provider."

Amount in Dispute: $1,050.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…it is the carrier's position that the bill was paid and denied correctly."

Response Submitted by: AIG, P.O. Box 25794, Shawnee Mission, KS 66225.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 19, 2012	Professional Services	$1,050.00	$285.91

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.203 sets our medical bill submission requirements for health care providers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 59 – Processed based on multiple or concurrent procedure rules.
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

1. Is the service in dispute separately payable?
2. Is the requestor entitled to reimbursement?

Findings

1. The service in dispute was denied, in part, due to "The benefit for this service is included in payment/allowance for another service/procedure..." 28 TAC §134.203(b)(1) states, in pertinent part, "for coding, billing, reporting and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits..." Medicare's CCI edits indicate whether a service billed is considered a component procedure of another service provider on the same day. CCI edits may be found at http://www.cms.gov. The requestor billed 76942. Review of the CCI public files, along with the medical bill provided by the parties finds that CMS payment policy allows one unit of service for any radiologic guidance for needle placement by different modalities. For that reason, 76942 are separately payable for one unit of service. Therefore, this service will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2011, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV Fact) x Non-Facility Price or:

Code	MAR Calculation	Units	Allowable
76942 (26)	(54.86 / 34.0376) x 177.39	1	$285.91
		Total	$285.91

The total allowable for the disputed service is $285.91. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor or $285.91. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $285.91.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $285.91 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.